Crohn's Disease / Ulcerative Colitis
Patient Enrollment & Prescription Form

Tel: 844-443-6879 Fax: 844-329-2447

ePrescribe to our pharmacy at "GENTRY HEALTH SERVICES" in Avon Lake, Ohio.

PATIENT INFORMATION

Patient Name _____
DOB ___/___/_____ SSN _____ Gender_____
Weight _____ Height _____ Phone _____
Address _____
City, State, Zip _____
Cell Phone _____ E-Mail _____

PLEASE PROVIDE COPY OF PATIENT'S PRESCRIPTION INSURANCE CARD WITH ENROLLMENT FORM

Insurance Co. Name _____
Insurance Co. Phone _____ Group# _____
Policy Holder Name _____
Policy Holder Employer _____
Relationship to Patient _____
ID# _____ RxBIN _____ PCN_____

PRESCRIBER INFORMATION

Prescriber's Name _____
Practice Name _____
DEA _____ NPI _____
Address _____
City, State, Zip _____
Phone _____ Fax _____
Office Contact Person _____
Office Contact EMAIL _____
Prescription Date _____ Date Needed _____

With my signature on this form, I also authorize use of Gentry Health's Services which includes serving as my prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescriber Signature _____

Ship to: ☐Patient ☐Prescriber's Office ☐Discount Drug Mart

PLEASE PROVIDE ALL RELEVANT CHART NOTES FOR INSURANCE PURPOSES

Medical Information (DO NOT COMPLETE IF CHART NOTES ARE PROVIDED)

Diagnosis _____ Date of Diagnosis _____
ICD-10 Code: _____ New to therapy? ☐ YES ☐ NO
TB negative? ☐ YES ☐ NO Hepatitis B negative? ☐ YES ☐ NO
Drug Allergies _____ Latex Allergy? ☐ YES ☐ NO
Prior Therapy and for how long? _____
Reason for Discontinuation? _____
Any other relevant medical info? _____

PRESCRIPTION INFORMATION *(DAW requests must be handwritten)*

☐ **Cimzia® (certolizumab)** ☐ 200mg/1ml Prefilled Syringe Starter Kit
Directions: Inject 400 mg SQ initially and at Weeks 2 and 4 Qty: 6 Refills 0
☐ 200mg/1ml Prefilled Syringe for Maintenance Dosing
Directions: ☐ Inject 400 mg SQ every 4 wks **OR** ☐ Inject 400 mg SQ every 2 wks Qty: QS 30 Days Refills _____

☐ **Humira® (adalimumab)** ☐ Crohn's 40mg Starter Package
Directions: Inject 160 mg SQ initially followed by 80mg two weeks later (Day 15) Qty: 1 KIT Refills 0
☐ 40mg Prefilled Pen Carton for Maintenance Dosing
Directions: Inject 40mg every other week Qty: QS 30 Days Refills _____

☐ **Remicade® (infliximab)** ☐ 100mg/20ml Vial Qty: QS 30 Days Refills _____
Directions: ☐ Infuse 5mg/kg at 0, 2 and 6 weeks, then every 8 weeks **OR** ☐ Infuse 10mg/kg at 0, 2 and 6 weeks, then every 8 weeks

☐ **Simponi® (golimumab)** TYPE: ☐ Smartject® Autoinjector ☐ Prefilled Syringe STRENGTH: ☐ 100mg
Directions: Inj 200 mg SQ initially at Week 0, followed by 100 mg at Week 2, then 100 mg every 4 weeks Qty: QS 30 Days Refills _____

☐ **Stelara® (ustekinumab)** ☐ 130mg Single Dose Vial ☐ 90mg single-dose prefilled syringe
☐ 260mg Starter (up to 55kg): Infuse intravenously over a period of at least one hour as directed
☐ 390mg Starter (greater than 55kg to 85kg): Infuse intravenously over a period of at least one hour as directed
☐ 520mg Starter (greater than 85mg): Infuse intravenously over a period of at least one hour as directed
☐ MAINTENANCE: Inject 90mg SQ every 8 weeks after initial intravenous dose 60 Days Supply? ☐YES ☐NO Refills _____

☐ **Xeljanz® (tofacitinib)** 5mg Tablet ☐Take 1 tablet twice daily Qty: 60
10mg Tablet ☐Take 1 tablet twice daily Qty: 60 Refills _____

CONFIDENTIALITY NOTICE: THE INFORMATION IN THIS TRANSMITTAL IS CONFIDENTIAL AND INTENDED ONLY FOR THE RECIPIENT LISTED ABOVE. IF YOU ARE NEITHER THE INTENDED RECIPIENT NOR A PERSON RESPONSIBLE FOR DELIVERING THIS TRANSMITTAL TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISTRIBUTION OR COPYING OF THIS TRANSMITTAL IS PROHIBITED. IF YOU RECEIVE THIS TRANSMITTAL IN ERROR, PLEASE IMMEDIATELY NOTIFY US AND RETURN THE TRANSMITTAL TO US AT OUR EXPENSE.